Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

JEFFREY ALLAN FISCHER,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

1. Whether Medicare payments to a hospital for services provided to Medicare patients qualify as "benefits" to meet the jurisdictional requirements of Title 18 U.S.C. § 666 so as to federalize crimes of theft, embezzlement, and bribery involving the hospital?

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

The undersigned counsel on behalf of Petitioner Jeffrey Allan Fischer, hereby certifies that to the best of his knowledge and belief, the following is an accurate listing of all persons and entities with an interest in the outcome of this case.

BAKER, DAVID A., United States Magistrate Judge

COLLAZO, CYNTHIA, Assistant United States Attorney.

CONWAY, ANNE C., United States District Judge

DIETRICH, DONALD P., United States Magistrate Judge

FISCHER, JEFFREY A., Defendant/Appellant

HORWITZ, MARK L., Attorney for Defendant/ Appellant, Jeffrey A. Fischer

PHIPPS, TAMRA, Assistant United States Attorney

QUALITY MEDICAL CONSULTANTS, INC.

RHODES, DAVID P., Assistant United States Attorney

WEST VOLUSIA HOSPITAL AUTHORITY

WILSON, CHARLES R., United States Attorney

This is a crime in which the victim is the West Volusia Hospital Authority.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit that gives rise to this petition is *United States v. Fischer*, 168 F.3d 1273 (11th Cir. 1999). (*App.* 1). By order filed April 28, 1999, the Eleventh Circuit denied the Petition for Rehearing and Suggestion for Rehearing *En Banc*. (*App.* 16).

JURISDICTION

The district court imposed sentence on Fischer on October 25, 1996. Fischer timely appealed to the Eleventh Circuit, which affirmed in an opinion filed on March 4, 1999. On April 28, 1999, the Eleventh Circuit denied Fischer's timely-filed motion for rehearing and suggestion for rehearing *en banc*. Pursuant to Supreme Court Rule 13.1, this petition has been filed within 90 days of the denial of rehearing.

The jurisdiction of the court is invoked pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved herein:

Title 18 U.S.C. § 666, Theft or bribery concerning programs receiving Federal Funds

(a) Whoever, if the circumstances described in subsection (b) of this sections exists –

(1) being an agent of an organization, or of a State, local, or Indian tribal government, or any agency thereof –

(A) embezzles, steals, obtains by fraud, or otherwise without authority knowingly coverts to the use of any person other than the rightful owner or intentionally misapplies, property that –

(i) is valued at $5,000 or more, and

(ii) is owned by, or is under the care, custody, or control of such organization, government, or agency; or

(B) corruptly solicits or demands for the benefit of any person, or accepts or agrees to accept, anything of value from any person, intending to be influenced or rewarded in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of $5,000 or more; or

(2) corruptly gives, offers, or agrees to give anything of value to any person, with intent to influence or reward an agent of an organization or of a State, local or Indian tribal government, or any agency thereof, in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of $5,000 or more;

shall be fined under this title, imprisoned not more than 10 years, or both.

(b) The circumstances referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.

(c) This section does not apply to bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business.

(d) As used in this section –

(1) the term "agent" means a person authorized to act on behalf of another person or a government and, in the case of an organization or government, includes a servant or employee, and a partner, director, officer, manager, and representative;

(2) the term "government agency" means a subdivision of the executive, legislative, judicial, or other branch of government, including a department, independent establishment, commission, administration, authority, board, and bureau, and a corporation or other legal entity established, and subject to control, by a government or governments for the execution of a governmental or intergovernmental program;

(3) the term "local" means of or pertaining to a political subdivision within a State;

(4) the term "State" includes a State of the United States, the District of Columbia, and any commonwealth, territory, or possession of the United States; and

(5) the term "in any one-year period" means a continuous period that commences no earlier than twelve months before the commission of the offense

or that ends no later than twelve months after the commission of the offense. Such period my include time both before and after the commission of the offense.

STATEMENT OF THE CASE

Mr. Fischer was indicted by a federal grand jury in Orlando, Florida on December 7, 1995. (R1/1) A superseding indictment was filed on June 12, 1996 which added several money laundering counts. (R1/51)

The charges all stemmed from a loan made to Quality Medical Consultants, Inc. ("QMC") by the West Volusia Hospital Authority ("Hospital Authority") which the government contended was procured by a bribe of $10,000 arranged by QMC's president and part owner, Fischer, to the Chief Financial Officer of the Hospital Authority. (R1/51)

Counts One and Two charged violations under 18 U.S.C. § 666 which alleged that Fischer obtained the $1.2 million loan by fraud and that Fischer bribed the Chief Financial Officer of the Hospital Authority to get the loan. (R1/51) Counts Three through Six alleged conspiracy, wire and mail fraud, all stemming from the same incident. (R1/51) Counts Seven through Thirteen alleged money laundering under 18 U.S.C. § 1957. The money laundering counts provided that the specified unlawful activity was 18 U.S.C. § 666.

At trial the evidence established that QMC received the proceeds from the $1.2 million loan from the Hospital Authority on July 2, 1993. (R6/398) In late August 1993 QMC at the direction of the Chief Financial Officer of the Hospital Authority paid $10,000 to the Chief Financial Officer's mother.

The defense contended that the $10,000 payment was an after-the-fact gratuity rather than a bribe. The defense also sought to establish that the loan was a bona fide debt of QMC.

The proof at trial revealed that the Hospital Authority was a separate taxing district that operated hospitals in Volusia County, Florida. (R7/631) The Hospital Authority received no federal funds except payment for services provided to Medicare and Medicaid patients, in the same manner as a private hospital. (R7/567-568; 620-621)

Additionally, testimony was presented that in 1993 the Hospital Authority received between $10-15 million from Medicare. (R7/567-568) No other evidence was presented which established any other sums paid by the Federal Government to the Hospital Authority.

REASONS FOR GRANTING THE WRIT

I. The Eleventh Circuit's Opinion Directly Conflicts With The Tenth Circuit's Opinion In *United States v. LaHue*, 170 F.3d 1036 (10th Cir. 1999) (*App.* 18) Which Establishes That Payments To Health Care Providers For services To Medicare Patients Do Not Meet The Jurisdictional Requirements Of $10,000 In Benefit Payments Per 18 U.S.C. § 666(b).

The continuous expansion of federal law enforcement into areas traditionally belonging to state and local governments is contrary to the fundamentals of federalism. In this case, the government utilized 18 U.S.C. § 666 to reach theft and bribery concerning a local hospital which has been traditionally subject to state criminal law enforcement.

The theft and bribery in this case was made a federal crime under 18 U.S.C. § 666 because the Hospital Authority received payment for providing services to Medicare and Medicaid patients. In affirming the conviction, the Eleventh Circuit has turned every theft, bribery, robbery, and embezzlement in excess of $5,000 from or involving a health care provider, (hospital, doctor, or nursing home), into a federal offense under 18 U.S.C. § 666 (as long as the provider received $10,000 in Medicare or Medicaid funds).

The Tenth Circuit in *LaHue* held that 18 U.S.C. § 666 did not apply when the provider was simply being paid for providing services to Medicare beneficiaries, *i.e.*, the patients. (*App.* 20)

To establish that Mr. Fischer had violated 18 U.S.C. § 666(a)(1) and (a)(2) the Government was required to

prove, in part, that the Hospital Authority was an entity which received " . . . benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." 18 U.S.C. § 666(b). The only evidence presented to support this requirement was testimony that the Hospital Authority received between $10-15 million in Medicare payments during the relevant period. (*App.* 7) There was no further testimony as to whether this payment by Medicare was pursuant to Medicare Part A or Part B.

On this record the Eleventh Circuit concluded that the Medicare program was a "federal assistance program" and therefore the Hospital Authority's receipt of these funds satisfied Section 666(b). (*App.* 9) The Eleventh Circuit stated, "[b]ecause WVHA received payments under a federal assistance program, WVHA received a type of 'benefits' expressly covered by § 666(b)." (*App.* 11) Therefore under the Eleventh Circuit's holding Section 666(b) is satisfied if the subject agency or private company receives payments which originated from a "federal assistance program," even if the payment is for providing services or selling a product.

The Tenth Circuit in *LaHue* found that payments under Medicare Part B did not satisfy Section 666(b) as the payments did not constitute a "benefit" contemplated by the statute. (*App.* 32) The benefits were received by the Medicare patients. (*App.* 22) The payments to the health care provider was therefore held a payment for services, not a benefit under the statute. (*App.* 23)

In *LaHue* the government argued that the language of Section 666(b) was sufficiently broad to encompass the

receipt of assigned payments under the Medicare Act. (*App.* 25) The *LaHue* court found that under the government's reading of Section 666(b) all monies could be considered federal benefits as long as the funds originated under a federal assistance program. (*App.* 26) This result would lead to virtually limitless liability under Section 666 since once a federal payment had been made to the intended beneficiary, the further assignment of that payment would still fall within the statute. (*App.* 26) The *LaHue* court concluded that such a result was particularly egregious in light of the fact that Section 666 is a criminal statute. (*App.* 25)

Given the interpretation sought by the government the *LaHue* court found Section 666(b) to be ambiguous. Specifically the *LaHue* court found that it was unclear what Congress intended in Section 666(b) by employing the language, "receives . . . benefits . . . under a Federal Program." (*App.* 28)

To resolve the ambiguity of Section 666(b) the *LaHue* court looked to the legislative history and underlying purpose of the statute. (*App.* 28) The legislative history disclosed that the underlying purpose of the statute was "to protect the integrity of the vast sums of money distributed through federal programs from theft, fraud, and undue influence by bribery." S.Rep.No. 95-225 at 370 (1984), reprinted in 1984 U.S.C.C.A.N. 3182, 3511. (*App.* 28)

In applying the legislative history the *LaHue* court concluded:

> . . . that Congress intended the reference in section 666(b) to an organization receiving federal program benefits to mean one that receives benefits before final distribution to the intended beneficiary, here the patient. What happens to the funds once the patient receives them is beyond the scope of section 666. Thus, any assignment of such funds to a third party does not constitute a receipt of federal program benefits within the reach of section 666. We are not persuaded it was Congress's intent in enacting section 666(b) to follow the intended beneficiaries' further distribution of the federal benefits.

(*App.* 32)

The *LaHue* court's analysis regarding the interpretation of Section 666 is consistent with that of other courts. In *United States v. Wyncoop*, 11 F.3d 119, 123 (9th Cir. 1993) the court reasoned that an expansive interpretation of Section 666 would cause each theft in excess of $5,000 from a grocery store to constitute a federal offense due to the store's receipt of food stamps.

In *United States v. Copeland*, 143 F.3d 1439, 1441 (11th Cir. 1998) another panel of the Eleventh Circuit rejected the government's interpretation of the term "federal assistance" which would have encompassed federal payments to defense contractors. The court found that while defense contracts might be "unique" since contractors were provided with detailed specifications for armament this was insufficient to establish that the contractor had itself received a "benefit" as required by the statute. *Id.* at 1442. Rather the court concluded that defense contractors were merely engaged in commercial transactions with the federal government. *Id.* There should be no distinction

between the protection afforded federal payments for jet fighters under the National Defense Program and federal payments for medical services under the Medicare Program.

The Eleventh Circuit's opinion in *Fischer* permits amounts paid to any hospital or health care provider under Medicare or Medicaid to constitute a benefit for jurisdictional purposes under Section 666 merely because the payment originated from a federal assistance program. This holding therefore permits virtually endless federal jurisdiction under Section 666. Furthermore, this conclusion is contrary to the plain language of 18 U.S.C. § 666(c) which specifically excludes from consideration amounts reimbursed by the Federal Government.

Congress specifically chose to exclude certain items from the scope of Section 666. These excluded items are listed in § 666(c) which provides: "This section does not apply to bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business." As Medicare payments are reimbursement to the health care provider for services rendered to beneficiaries these amounts are specifically excluded from Section 666.

The Medicare Act has been reviewed by this Court in two recent decisions. *Your Home Visiting Nurse Services, Inc. v. Shalala*, ___ U.S. ___, 119 S.Ct. 930, 142 L.Ed.2d 919 (1999) and *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87 (1995). In each of these cases this Court has adhered to the plain language of the Medicare Statute and has determined that providers of health care are only entitled to reimbursement for services rendered.

This Court stated in *Your Home Visiting Nurse Services, Inc.* the following:

> Under the Medicare Act, Title XVIII of the Social Security Act, 79 Stat. 290, as amended, 42 U.S.C. § 1395 (1994 ed. and Sup. II), *et seq.*, the Secretary of Health and Human Services reimburses the providers of covered health services to Medicare beneficiaries, see §§ 1395f(b)(1), 1395h, 1395x(v)(1)(A). A provider seeking such reimbursement submits a yearly cost report to a fiscal intermediary (generally a private insurance company) that acts as the Secretary's agent. See 42 C.F.R. § 405.1801(b) (1997). The intermediary analyzes the cost report and issues a Notice of Program Reimbursement (NPR) determining the amount of reimbursement to which the provider is entitled for the year. See § 405.1803.

Your Home Visiting Nurse Services, Inc., 119 S.Ct. at 932.

Furthermore, participating hospitals are only reimbursed for "reasonable costs". Reasonable costs are defined by statute to be, "the cost actually incurred excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. § 1395x(v)(1)(A)." *Guernsey Memorial Hospital*, 514 U.S. at 92.

Similarly, this Court noted that the secretary is authorized to promulgate regulations to determine reasonable costs. *Id.* The secretary is further under a mandate to ensure that the [Medicare] program bears neither more nor less than its fair share of costs. 42 U.S.C. § 1395x(v)(1)(A)(i) ("[T]he necessary costs of efficiently delivering governed services to individuals covered by

[Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].") *Id.* at 97, 98.

While health care providers may enjoy having additional patients to service due to Medicare payments these providers must nonetheless ply their trade to receive payment under the program. Additionally under the Medicare statutory framework health care providers are not responsible for administering federal funds since health care providers are only entitled to reimbursement.

A canon of statutory construction mandates that, "[c]ourts in applying criminal laws generally must follow the plain and unambiguous meaning of statutory language. 'Only the most extraordinary showing of contrary intentions' in the legislative history will justify a departure from that language." *Salinas v. United States*, 522 U.S. 52, 118 S.Ct. 469, 474, 139 L.Ed.2d 352 (1997).

The *LaHue* court recognized that the purpose of Section 666 was to protect federal funds from diversion by direct beneficiaries and those who administer or disburse funds for the benefit of individual beneficiaries. The *Fischer* decision expands the statute's reach to any health care provider that receives payments for services. Such a result is beyond the statute's reach and expands federal law enforcement into areas belonging to local and state governments.

II. The Eleventh Circuit's Decision Is Arguably In Conflict With The Second Circuit's Opinion In *United States v. Zyskind*, 118 F.3d 113 (2d Cir. 1997) And The Ninth Circuit's Opinion In *United States v. Wyncoop*, 11 F.3d 119 (9th Cir. 1993) As Each Of Those Circuits Has Determined That 18 U.S.C. § 666 Does Not Extend To Situations Where The Agency Which Receives Federal Funds Does Not Administer Those Funds.

The Eleventh Circuit's opinion as to the scope of Section 666 creates a significant circuit split. A review of decisions from the Second Circuit and the Ninth Circuit indicates that the Eleventh Circuit's decision greatly expands the scope of § 666 beyond the holdings of each of those circuits.

In *Zyskind* the administrators of an adult home received federal funds which they were to administer for the benefit of a resident of the home. *Zyskind*, 118 F.3d at 114. At issue was whether the adult home that received the federal funds and administered those funds in a fiduciary capacity for the residents of the home received a benefit with the meaning of Section 666(b). *Id.* at 115.

In *Zyskind* the fiduciary duty of the defendant was based on an agreement the defendant entered into with the Veterans' Administration. Under the agreement the defendant was entitled to receive and administer federal funds paid on behalf of a resident of the adult home. The V.A. was authorized to enter the agreement pursuant to 38 U.S.C. § 3202(a)(1) (1988), which permitted the V.A. to pay benefits due and owing to a beneficiary to a caretaker or custodian. *Id.*

As the defendant in *Zyskind* was responsible for the administration and further distribution of these funds the court found that the defendant did fall within Section 666. *Id.* at 116.

In conclusion the *Zyskind* court stated that Section 666 was enacted "to prevent diversions of federal funds not only by agents of organizations that are direct beneficiaries of federal benefits funds, but by agents of organizations to whom such funds are 'disbursed' for further 'distribution' to or for the benefit of the individual beneficiaries." *Id.*

Under the Second Circuit's analysis in *Zyskind* as applied to the instant case, Section 666 would not be satisfied. The receipt of $10-15 million of Medicare payments by the Hospital Authority is not a benefit to the Hospital Authority, but rather a payment of services. The benefit is received by the patient in the form of having the medical bills paid. Likewise, the Hospital Authority was not administering or disbursing funds for the patients. The payment received became the property of the Hospital Authority. Once the Hospital Authority received this payment of the $10-15 million from Medicare, it could use this money according to its own policies. The federal government had no further interest in ensuring that this money was utilized to achieve any federal goals.

However, the decision of the Eleventh Circuit extends Section 666 to the Hospital Authority even though the Hospital Authority has no obligation to continue to administer these funds in conformance with any federal program.

Likewise, the Ninth Circuit's decision in *Wyncoop* is in conflict with the Eleventh Circuit's decision. In *Wyncoop* a private college participated in the federal student loan programs. *Wyncoop*, 11 F.3d at 121. The government sought to establish jurisdiction under Section 666 on the basis of the college's receipt of tuition payments funded by the student loan program. *Id.*

The *Wyncoop* court found that the intended beneficiaries of the student loan program were students. *Id.* Additionally, the participating college was not responsible for administering any federal funds. *Id.* at 122. Therefore, the *Wyncoop* court concluded that Section 666 was not satisfied as the college in question did not receive benefits as required by Section 666(b). *Id.* The court also noted that the college enjoyed a benefit in the sense that the college's enrollment increased due to the existence of the federal student loan program, but, since the college was not itself the intended beneficiary and did not administer any federal funds, Section 666 was not satisfied. *Id.* at 121-22.

Under the Ninth Circuit's analysis in *Wyncoop* as applied to the instant case, Section 666 would not be satisfied. The mere receipt of Medicare reimbursement payments is not a benefit to the Hospital Authority as contemplated under the statute. Furthermore, the Hospital Authority is not responsible for administering any federal funds.

Therefore, in the Second, Ninth, and Tenth Circuits, citizens may engage in behavior which would not subject them to federal prosecution, but the same behavior would be a federal offense in the Eleventh Circuit. These

cases present a significant conflict on the reach of 18 U.S.C. § 666.

CONCLUSION

The Eleventh Circuit has greatly extended the scope of Section 666. The Eleventh Circuit merely requires that a benefit be received from a "federal assistance program". Whether the benefit is derived directly from the federal government or indirectly is immaterial to the Eleventh Circuit's analysis. Furthermore, the Eleventh Circuit failed to utilize the exclusions found in Section 666(c) which excludes in part amounts paid by the federal government as "reimbursement". Without employing the safeguards found in Section 666(b) and (c) the Eleventh Circuit has created a statute of virtually endless federal jurisdiction over health care providers who service Medicare and Medicaid patients. Therefore, this cause merits the immediate attention of this Court and the writ should be granted.

Respectfully submitted,

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UNITED STATES of America,
Plaintiff-Appellee,

v.

Jeffrey Allan FISCHER,
Defendant-Appellant.

Nos. 96-3587, 97-2877 and 98-2091.

United States Court of Appeals,
Eleventh Circuit.

March 4, 1999.

Mark L. Horwitz, Orlando, FL, for Defendant-Appellant.

Charles R. Wilson, U.S. Atty., Tamra Phipps, Susan Humes Raab, David P. Rhodes, Asst. U.S. Attys., Tampa, FL, for Plaintiff-Appellee.

Appeal from the United States District Court for the Middle District of Florida.

Before ANDERSON and HULL, Circuit Judges, and HANCOCK*, Senior District Judge.

HULL, Circuit Judge:

A jury convicted appellant Jeffrey Allan Fischer on thirteen counts, including violations of 18 U.S.C. §§ 371 (conspiracy), 666 (fraud and bribery involving an organization receiving federal funds), 1341 (mail fraud), 1343 (wire fraud), and 1957 (money laundering).[1] Fischer appeals his convictions and sixty-five-month sentence.

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* Honorable James H. Hancock, Senior U.S. District Judge for the Northern District of Alabama, sitting by designation.

[1] The jury convicted Fischer of one count of fraud involving an organization receiving federal funds, in violation of 18 U.S.C.

Fischer contends, *inter alia*, that his convictions on two counts under § 666 and on a related conspiracy count should be reversed because the Government did not prove the statutory prerequisite that the agency affected by Fischer's wrongdoing "receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." 18 U.S.C. § 666(b).[2] After review, we affirm Fischer's convictions and sentence.

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§ 666(a)(1)(A) (Count I); one count of giving a kickback to an agent of an organization receiving federal funds, in violation of 18 U.S.C. § 666(a)(2) (Count II); one count of mail fraud, in violation of 18 U.S.C. § 1341 (Count III); two counts of wire fraud, in violation of 18 U.S.C. § 1343 (Counts IV-V); one count of conspiracy to commit fraud involving an organization receiving federal funds, to give and accept a kickback involving an organization receiving federal funds, and to commit wire fraud, in violation of 18 U.S.C. § 371 (Count VI); and seven counts of money laundering, in violation of 18 U.S.C. § 1957 (Counts VII-XIII).

[2] Fischer also challenges (1) the sufficiency of the evidence regarding his intent to defraud and to bribe, (2) the particularity of the indictment, (3) the admission of evidence relating to his prior fraud convictions, (4) certain statements by the prosecutor during opening statement and closing argument, (5) the district court's decision not to hold an evidentiary hearing in reference to a *Brady* violation alleged in Fischer's motions for a new trial, and (6) the district court's finding that Fischer had the ability to pay restitution. After careful consideration of each of these claims, we affirm the judgment of the district court. *See* 11th Cir.R. 36-1.

I. BACKGROUND

A. $1.2 Million Loan

At trial, the evidence established that in 1993 Fischer, as president and part-owner of QMC, arranged for West Volusia Hospital Authority ("WVHA") to loan $1.2 million to QMC. Fischer negotiated this loan with WVHA's chief financial officer, Robert Caddick. On June 30, 1993, Fischer and Caddick executed the loan agreements between QMC and WVHA.

As security for the $1.2 million loan, Fischer pledged QMC's accounts receivable and a $1 million letter of credit QMC had obtained for this purpose through a foreign bank, First Asia Development Bank ("FADB"). However, QMC's accounts receivable already were pledged to another QMC creditor. In addition, the $1 million letter of credit did not appear to be legitimate, and even if it were, its terms severely limited WVHA's ability to collect the $1 million.[3]

Furthermore, questions were raised about WVHA's authority to loan money to QMC. The questions arose both before WVHA loaned the $1.2 million to QMC, and later, when WVHA's board of directors discovered the

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[3] After reviewing the $1 million letter of credit, the account representative at WVHA's bank expressed concerns to Caddick and to Fischer about the legitimacy of the letter of credit and about WVHA's ability to collect on the letter of credit, if necessary. The account representative's concerns were based on the facts that she had never heard of FADB and that the letter of credit had not been signed, would expire even before the WVHA-QMC loan matured, and required QMC's approval before WVHA could collect on it.

loan had been made. WVHA, a local government agency funded by a bond issue, was authorized to invest its excess funds in only instruments backed by the federal government.[4]

Nonetheless, WVHA made the $1.2 million loan to QMC on July 2, 1993. QMC used the $1.2 million to repay creditors and to raise the salaries of QMC's five owner-employees, including Fischer. In addition, Fischer had QMC lend at least $100,000 to a company owned by the FADB representative who had assisted QMC with the $1 million letter of credit. Fischer also had QMC open options-trading accounts using these loan proceeds. In a short time, Fischer lost about $400,000 of the loan proceeds through his options-trading on QMC's behalf.[5]

In February 1994, WVHA's auditors disclosed the $1.2 million loan to QMC in the annual audit report. Through this report, WVHA's board of directors and the chairman of WVHA's finance committee first learned about the $1.2 million loan. Shortly thereafter the board

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[4] As a result of a proposal presented by Caddick in April 1993, WVHA's finance committee did expand Caddick's investment authority. At trial, however, evidence indicated that investment in loans to private entities, such as QMC, still would not have been authorized.

[5] To show that Fischer had a pattern of fraudulently obtaining money and then using that money to speculate in the securities market, the Government introduced evidence that Fischer, while a broker for E.F. Hutton, had embezzled two million dollars of his clients' money. Fischer thereafter lost the two million dollars in failed investments. As a result of these actions, Fischer was convicted on three counts of mail fraud on April 12, 1985.

asked that the loan be called. The due date for the loan was July 1, 1994.

On July 1, 1994, QMC did not have the funds to repay the loan. Later that month, Fischer persuaded FADB to send QMC a $1.2 million draft to repay WVHA. QMC endorsed this draft and presented it to WVHA, which in turn presented the draft to its bank. However, FADB refused to honor the draft when presented by WHVA's bank. Thus, WVHA was unable to collect the $1.2 million owed by QMC.

B. $10,000 Kickback to Caddick

The evidence indicated that, in June 1993, Caddick requested a $10,000 loan from QMC at the end of one of Fischer and Caddick's initial meetings about the possibility of the $1.2 million loan. After QMC received the $1.2 million loan from WVHA, QMC paid $10,000 by check to Caddick's mother, Stella Greenfield, in August 1993. This $10,000 check, paid with Fischer's approval, was marked "consulting fees" – even though Greenfield never performed any services for QMC. Greenfield sent the proceeds of the $10,000 check to Caddick, pursuant to Caddick's instructions.

In January 1994, a QMC bookkeeper sought an invoice to correspond with the earlier $10,000 check to Greenfield. The bookkeeper received an invoice dated August 1, 1993. A notation appeared on the invoice in Fischer's handwriting, indicating that the payment was for a "loan origination fee."

Another attempt to cover up QMC's $10,000 payment to Caddick apparently was made after QMC defaulted on the $1.2 million loan from WVHA and that default became the subject of an investigation and widespread publicity. In this cover-up attempt, Caddick allegedly approached QMC's vice-president, Charles Kramer, with a "contract" for programming services Caddick purportedly had performed for QMC. Caddick allegedly asked Kramer to sign and backdate the "contract" to create a retroactive justification for the $10,000 payment. However, Kramer refused.

C. WVHA's Receipt of Federal Benefits

To establish that Fischer had violated 18 U.S.C. §§ 666(a)(1) and (a)(2), the Government was required to prove that WVHA was an agency receiving, in any one year period, "benefits in excess of $10,000" under a federal assistance program. 18 U.S.C. § 666(b).[6] At trial, the

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[6] In relevant part, 18 U.S.C. § 666 provides as follows:

(a) Whoever, if the circumstance described in subsection (b) of this section exists –

(1) being an agent of an organization, or of a State, local, or Indian tribal government, or any agency thereof –

(A) embezzles, steals, obtains by fraud, or otherwise without authority knowingly converts to the use of any person other than the rightful owner or intentionally misapplies, property that –

(i) is valued at $5,000 or more, and

(ii) is owned by, or is under the care, custody, or control of such organization, government, or agency; or

Government introduced evidence that WVHA was a county agency responsible for operating two county hospitals. The Government also introduced testimony from WVHA's director of finance that "most health care organizations collect a majority of their funds from programs that are funded by the federal government." Asked to give an example of how much money WVHA specifically collected in 1993 from the federal government under the Medicare program alone, WVHA's director of finance testified that WVHA had collected between ten and fifteen million Medicare dollars in 1993.

Later on, WVHA's director of finance explained further that different government programs pay differently. WVHA's director of finance then testified:

. . . .

(2) corruptly gives, offers, or agrees to give anything of value to any person, with intent to influence or reward an agent of an organization or of a State, local, or Indian tribal government, or any agency thereof, in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of $5,000 or more; shall be fined under this title, imprisoned not more than 10 years, or both.

(b) The circumstance referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.

18 U.S.C. §§ 666(a)-(b).

> A specific example is that we get paid, hospitals get paid a fixed amount from the federal government on in-patient Medicare patients, patient[s] who are greater than the age of 65. So raising the prices for services that are primarily used for individuals in that group has no impact. There's no increase in revenue.

Thus, according to the testimony of WVHA's director of finance, even if the hospital charges the patient an increased amount for services, the hospital is paid only a fixed amount from Medicare for those services.

II. DISCUSSION[7]

A. Scope of § 666(b)

The statutory prerequisite for a conviction under 18 U.S.C. § 666 is that the organization or agency affected by the fraud, unauthorized conversion, bribery, or other prohibited act "receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." 18 U.S.C. § 666(b). In the present case, the primary issue is whether WVHA received "benefits" under a federal assistance program

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[7] The issues we discuss here involve statutory interpretation and sufficiency of the evidence. We review *de novo* issues of statutory interpretation. *United States v. MacAllister*, 160 F.3d 1304, 1306 (11th Cir.1998). We also review *de novo* sufficiency of the evidence, viewing the evidence in the light most favorable to the Government and drawing all reasonable inferences and credibility choices in favor of the jury's verdict. *United States v. Trujillo*, 146 F.3d 838, 845 (11th Cir.1998).

for purposes of § 666(b). After review, we find that WVHA's receipt of between ten and fifteen million dollars in Medicare funds qualified as receipt of "benefits" under a federal assistance program and that the Government presented sufficient evidence to satisfy the requirements of 18 U.S.C. § 666(b).

This Court previously addressed the scope of § 666(b) in *United States v. Copeland*, 143 F.3d 1439 (11th Cir.1998). At issue in *Copeland* was whether Lockheed, a prime contractor for the United States Department of Defense, qualified as an organization receiving "benefits" for purposes of § 666(b). *Id.* at 1441. Defendant Copeland, a manager at one of Lockheed's plants, had been convicted of violating 18 U.S.C. § 666 by accepting bribes from individuals including co-defendant Winders. *Id.* at 1440. In turn, defendant Winders had been convicted of violating 18 U.S.C. § 666 by giving bribes to co-defendant Copeland. *Id.* On appeal, the defendants argued that their convictions under § 666 should be reversed because the Government had failed to prove that Lockheed met the requirements of § 666(b). *Id.*

In reviewing the defendants' claims in *Copeland*, this Court examined the statutory language and construed § 666(b) as requiring that the "benefits" an organization or agency receives from the federal government be linked to some form of federal assistance. *Id.* at 1441. Specifically, this Court recognized that organizations engaging in contractual relationships with the federal government would fall within the scope of the statute, if those "contractual relationships constitut[ed] some form of 'Federal assistance.' " *Id.* This Court also determined that "organizations engaged in purely commercial transactions with

the government" were excluded from the scope of § 666(b) because those organizations were not in relationships involving some form of federal assistance. *Id.*

Based on the evidence at trial, this Court in *Copeland* concluded that Lockheed's relationship with the government did not come within the scope of § 666(b) because Lockheed's transactions as a defense contractor were "purely commercial." *Id.* at 1442. Nothing in the record indicated that Lockheed had received "benefits" under a federal program involving a contract or any other form of federal assistance. *Id.* The record did contain evidence that Lockheed received funds from the government through its defense contracts, but those funds were not "benefits" within the meaning of § 666(b) because those funds were not received under a federal program involving federal assistance. *Id.* Instead, those funds were received as a result of "purely commercial transactions with the government." *Id.* Because this statutory prerequisite of receiving "benefits" under a program of federal assistance was not met, this Court vacated Copeland's and Winders's convictions under § 666. *Id.*

B. Sufficiency of the Government's Evidence Under § 666(b)

The evidence in the present case contrasts sharply with that in *Copeland*. Whereas Lockheed received federal dollars through purely commercial transactions, WVHA, as an agency responsible for the administration of two hospitals, actually received payments from the federal government under several federal assistance programs. For example, evidence introduced at the trial in this case

clearly established that, in 1993, WVHA received between ten and fifteen million dollars under the federal Medicare assistance program. In fact, WVHA's finance director's testimony indicated that the ten to fifteen million dollars WVHA collected under the Medicare program in 1993 was paid directly to WVHA for providing health care services to covered individuals.

Section 666(b) provides that the "benefits" an organization receives under a federal program can be in the form of "a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." 18 U.S.C. § 666(b) (emphasis added). Because WVHA received payments under a federal assistance program, WVHA received a type of "benefits" expressly covered by § 666(b). Thus, the statutory prerequisite for Fischer's convictions under § 666 was satisfied.

Having reached this result based entirely on the plain language of § 666(b), we normally would not examine the legislative history of the statute. *See United States v. Copeland*, 143 F.3d 1439, 1441 (11th Cir.1998). However, as this Court observed in *Copeland*, some circuits have found § 666(b) to be ambiguous on its face. *Id.* As a result, it is worth noting that the legislative history of § 666(b) also supports our conclusion. The statute's legislative history indicates that the language of § 666(b) is to "be construed broadly, consistent with the purpose of this section to protect the integrity of the vast sums of money distributed through Federal programs from theft, fraud, and undue influence by bribery." S.Rep. No. 225, 98th Cong., 2d Sess. 369-70 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3510-11. In this case, our determination that WVHA is an agency receiving "benefits" within the meaning of

§ 666(b) serves the statute's purpose of protecting from fraud, theft, and undue influence by bribery the money distributed to health care providers, and WVHA in particular, through the federal Medicare program and other similar federal assistance programs.[8]

C. "Target Recipient" Analysis Not Required

Fischer's main argument that the Medicare funds received by WVHA are not "benefits" for purposes of § 666(b) relies on a narrow construction of "benefits" that does not consider the context in which the term appears. Fischer primarily bases his argument on a district court decision in *United States v. LaHue*, 998 F.Supp. 1182 (D.Kan.1998). In *LaHue*, the court concluded that a group of physicians who received Medicare funds and, more

[8] Although the legislative history may seem to indicate otherwise, we observe that this Court already has held that the government is not required to prove a direct link between the federal assistance and the fraudulent conduct in issue. *United States v. Paradies*, 98 F.3d 1266, 1288-89 (11th Cir.1996) (recognizing that a "connection to federal funds" is not required for a conviction under § 666). Instead, § 666(b) only requires the government to prove that WVHA is an agency that receives "benefits in excess of $10,000" under a federal assistance program, as we have already determined that the government has done. *See* 18 U.S.C. § 666; *United States v. Copeland*, 143 F.3d 1439, 1441 (11th Cir.1998). Thus, here the government was not required to prove a direct link between the Medicare funds received by WVHA and either Fischer's fraudulently obtaining and converting the $1.2 million loan from WVHA or Fischer's bribing an agent of WVHA in connection with the $1.2 million loan.

specifically, funds under Medicare Part B,[9] as payment for their services had not received "benefits" for purposes of 18 U.S.C. § 666(b). *Id.* at 1186-87, 1192.

After reviewing the framework of the Medicare statute, the *LaHue* court concluded that Medicare patients, and not Medicare providers, are the "target recipients" of Medicare "benefits." *Id.* at 1185-86. In particular, the court observed that, under Part B of the Medicare program, patients may either pay their health care providers and then seek reimbursement from Medicare or may assign their "benefits" to their providers, allowing the providers to collect funds from Medicare. *Id.* at 1185. The *LaHue* court acknowledged that, under this framework, Medicare Part B providers "ultimately receive funds traceable to a federal program," but the court emphasized that these providers "do so only through patient payments or assignments." *Id.* at 1187. Thus, according to *LaHue*, the physicians' group involved in the case received funds under Part B of Medicare after those "benefits" had reached the "target recipients" of the program. *Id.* at 1187-88.

Finding the language of § 666(b) ambiguous as to whether these payments and assignments of funds that are traceable to Medicare Part B, but received "after" the funds have reached the "target recipients," qualify as "benefits" for purposes of § 666(b), the *LaHue* court examined the statute's legislative history. *Id.* at 1188-89. The *LaHue* court interpreted this legislative history, along

[9] The Medicare program is divided into two parts, Part A and Part B. *See* 42 U.S.C. § 1395, *et seq.*

with the few cases that have examined and applied § 666(b), as consistent with the court's conclusion that once the funds from a federal program reach the "target recipient," they cease to be "benefits" under a federal assistance program for purposes of § 666(b). *Id.* at 1187-90.

We decline to adopt *LaHue*'s "target recipient" analysis. We first note that, in this case, the testimony of WVHA's finance director indicated that in 1993 WVHA received ten to fifteen million dollars from the Medicare program. The finance director's testimony did not clearly establish whether WVHA received funds directly from the Medicare program or received funds as an assignee under Part B or even Part A of the federal program. Thus, there is a possibility in this case that WVHA received funds directly from the Medicare program without having been assigned the right to receive those funds by a patient. However, even if WVHA received funds as an assignee, the plain language of § 666(b) does not distinguish between an organization, government, or agency that receives "benefits" directly under a federal program and an organization, government, or agency that receives "benefits" as an assignee under a federal program.

Moreover, the language of § 666(b) also does not require that "the organization, government, or agency receiv[ing] . . . benefits" be the "target recipient" of the federal program at issue. Instead, the language focuses on the source of the "benefits", requiring that the "benefits" have been received "*under* a Federal program *involving* a grant, contract, subsidy, loan, guarantee, insurance, or other form of *Federal assistance*." 18 U.S.C. § 666(b) (emphasis supplied). Thus, in context, the use of the term

"benefits" serves to emphasize not that the recipient must be a "target recipient", but rather that the funds must have been received by the organization, government, or agency as part of an "assistance" program, rather than a purely commercial transaction – the federal government's purchase of goods from a contractor, for example. *See United States v. Copeland*, 143 F.3d 1439 (11th Cir.1998).

III. CONCLUSION

For all of the foregoing reasons, Fischer's convictions and sentence are AFFIRMED.

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Nos. 96-3587, 97-2877, and 98-2091

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

versus

JEFFREY ALLAN FISCHER,
Defendant-Appellant

On appeal from the United States District Court
for the Middle District of Florida

(Filed Apr. 28, 1999)

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

(Opinion _____, 11th Cir., 19__, ___F.2d ___).

Before: ANDERSON and HULL, Circuit Judges, and HANCOCK*, Senior District Judge.

PER CURIAM:

The petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate

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* Honorable James H. Hancock, Senior U.S. District Judge for the Northern District of Alabama, sitting by designation.

Procedure; Eleventh Circuit Rule 35-5), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Frank M. Hull
UNITED STATES CIRCUIT JUDGE

ORD-42
(6/95)

UNITED STATES of America, Plaintiff-Appellant,

v.

Robert C. LaHUE, doing business as Robert C. LaHue, D.O., Chartered, doing business as Blue Valley Medical Group; Ronald H. LaHue, Defendants-Appellees,

No. 98-3146.

United States Court of Appeals, Tenth Circuit.

March 23, 1999.

Sean Connelly, Attorney, Department of Justice, Denver, Colorado (Jackie N. Williams, United States Attorney, and Tanya J. Treadway, Asst. United States Attorney, District of Kansas, and William H. Bowne, Department of Justice, Washington, D.C., with him on the briefs), for Plaintiff-Appellant.

Jeffrey D. Morris, of Bryan Cave LLP, Overland Park, Kansas (James L. Eisenbrandt, of Bryan Cave LLP, Overland Park, Kansas, Nilesh S. Patel, Kansas City, Missouri, and Bruce Houdek, Kansas City, Missouri, with him on the briefs), for Defendants-Appellees.

Before SEYMOUR, Chief Judge, EBEL and KELLY, Circuit Judges.

SEYMOUR, Chief Judge.

Defendants Dr. Ronald LaHue and Dr. Robert LaHue, agents of Blue Valley Medical Group (BVMG), were indicted on one count of conspiracy under 18 U.S.C. § 371 (count 1), seven counts of Medicare fraud under the Anti-

Bribery Act, 18 U.S.C. § 666(b) (counts 2 through 8), one count of conspiracy under 18 U.S.C. § 286 (count 9), and one count of witness tampering under 18 U.S.C. § 1512 (count 10). The district court granted defendants' motion to dismiss counts 2 through 8 on the theory that BVMG did not receive federal benefits as required by section 666(b) and therefore was not within the ambit of the statute.[1] *United States v. LaHue*, 998 F.Supp. 1182, 1184 (D.Kan.1998). The government appeals, arguing that the alleged fraud falls within section 666(b) because BVMG

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[1] Section 666 provides in relevant part:

(a) Whoever, if the circumstance described in subsection (b) of this section exists –

(1) being an agent of an organization, or of a State, local, or Indian tribal government, or any agency thereof –

. . . .

(B) corruptly . . . accepts or agrees to accept, anything of value from any person, intending to be influenced or rewarded in connection with any business, transaction, or series of transactions of such organization, government, or agency involving anything of value of $5,000 or more;

. . . .

shall be fined under this title, imprisoned not more than 10 years, or both. (b) The circumstance referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.

18 U.S.C. § 666(a, b).

was a recipient of Medicare reimbursements assigned to it by its patients. We affirm the district court.

I

From 1985 to 1995, BVMG provided services in Kansas and Missouri as one of the largest geriatric care practices in the United States. Dr. Robert LaHue was president of BVMG and his brother, Dr. Ronald LaHue, was vice-president. The LaHues and other BVMG physicians provided medical services to nursing home residents and also referred patients to various hospitals for inpatient and outpatient care.

The indictment alleged that the LaHues engaged in a criminal scheme to receive bribes from various hospitals in return for referring Medicare patients to the hospitals. It asserted that the LaHues proposed and entered into a number of sham consulting agreements where BVMG received annual consulting "fees" from each hospital in amounts ranging from $50,000 to $150,000 in return for referring patients to the paying hospital. The government charged that the scheme constituted federal government program fraud in violation of section 666, which applies to an organization that receives "benefits" under a federal program.

The LaHues moved to dismiss the charges of program fraud, asserting that Medicare reimbursements to doctors are not benefits within the meaning of section 666(b). The district court agreed. The court determined that Medicare payments are extended by Congress to the patient, who is both the intended recipient of the funds and the intended beneficiary of Medicare. The patient is

permitted voluntarily to direct the funds to the medical provider through assignment. Under this pattern of disbursement, the district court held that reimbursements to BVMG physicians can not be characterized as section 666 benefits from a federal program because those benefits were disbursed to the patient before dissemination to BVMG. Accordingly, the district court dismissed the claims against BVMG under section 666.[2]

II

In reviewing the district court's determination, we must decide whether providers of medical services to Medicare Part B patients fall within the statutory jurisdiction of 18 U.S.C. § 666(b). In other words, are the LaHues agents of an organization, BVMG, that "receive[d] *benefits* in excess of $10,000 under a Federal Program." *Id.* (emphasis added) In making this determination, we look first at the nature of the Medicare program, and then assess section 666 in light of that program.

A. Medicare Part B

Many BVMG patients were eligible for Medicare reimbursements under 42 U.S.C. §§ 1395j-1395k and used the reimbursements to pay for BVMG services under Medicare Act Part B. The Medicare Act consists of two

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[2] After the dismissal, the government impaneled a new grand jury that indicted the LaHues for the same alleged conduct under an anti-kickback statute, 42 U.S.C. § 1320a-7b, which criminalizes the acceptance of bribes for Medicare patient referrals.

parts: Part A, Hospital Insurance Benefits for the Aged and Disabled, 42 U.S.C. §§ 1395c-1395i;[3] and Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, 42 U.S.C. §§ 1395j-1395w. Our case exclusively addresses Medicare Part B payments. Part B of the Medicare system was established to provide "benefits" to the individual beneficiary for use in paying the costs of certain medical services, including physicians' services. Part B is a voluntary program where beneficiaries pay monthly premiums that, along with federal government contributions, are remitted to the Federal Supplementary Medical Insurance Trust Fund. *See id.* § 1395t. The Department of Health and Human Services has responsibility for administering the program and contracts with private insurance carriers who evaluate and pay Part B claims out of the Trust Fund. *See id.* § 1395u.

Under Part B, a physician may either request direct payment by patients on the basis of an itemized bill or accept assignment agreements. Under an assignment agreement, the beneficiaries execute formal assignments of their individual benefits to the physicians to compensate the physicians for health care services. *See id.* § 1395u(h). A physician who does not accept assignment can charge her patient in excess of the Medicare allowed expense, a practice called "balance billing." Medicare

[3] Part A concerns institutional health providers (hospitals, nursing homes, rural health clinics) and is funded out of Social Security taxes. Payment by Medicare under Part A for services rendered by a hospital or other institution may only be made to the institution, and the institution may not bill the patient directly, except for deductibles and coinsurance. Part A is not implicated under the government's theory in this case.

pays eighty percent of reasonable reimbursable claims while the beneficiary is responsible for the remaining twenty percent and any "balance billing." *See* 42 U.S.C. § 1395l. The dismissed charges at issue here all involved patient assignments directing that their Medicare reimbursements be sent to the BVMG physicians to pay for medical services rendered. A BVMG physician who accepted assignment agreed to accept a specified amount as full payment for each service. This assignment scheme implies that the intended beneficiary of Medicare Part B is the patient. The Medicare statute reinforces this interpretation. It provides in relevant part:

> **Scope of benefits; definitions**
>
> (a) The benefits provided to an individual by the insurance program [Medicare] established by this part shall consist of –
>
> (1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services. . . .

42 U.S.C. § 1395k. As the statute reads, "benefits" are "provided to an individual," who has the authority to direct whether they are to be paid "to him or on his behalf." *Id.* With this in mind, we turn to an analysis of section 666.

B. 18 U.S.C. § 666

We review legal issues of statutory construction de novo. *United States v. Oberle*, 136 F.3d 1414, 1423 (10th Cir.1998). In interpreting section 666, we recognize that

the Supreme Court directs us to use restraint in interpreting federal criminal statutes. *Dowling v. United States*, 473 U.S. 207, 214, 105 S.Ct. 3127, 87 L.Ed.2d 152 (1985). "Courts in applying criminal laws generally must follow the plain and unambiguous meaning of the statutory language." *Salinas v. United States*, 522 U.S. 52, ___ , 118 S.Ct. 469, 474, 139 L.Ed.2d 352 (1997) (quoting *United States v. Albertini*, 472 U.S. 675, 680, 105 S.Ct. 2897, 86 L.Ed.2d 536 (1985)). Where the statute is ambiguous, we look to the legislative history and the underlying public policy of the statute. *See United States v. Simmonds*, 111 F.3d 737, 742 (10th Cir.1997).

The Anti-Bribery Act, 18 U.S.C. § 666, prohibits the unlawful acceptance of anything of value of $5,000 or more if the person taking the bribe is an agent of an organization subject to the statute. Whether an organization falls within the scope of the statute is determined pursuant to the limits of section 666(b), which reads:

> The circumstances referred to in subsection (a) of this section is that the organization, government, or agency receives, in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.

18 U.S.C. § 666(b). The district court acknowledged the superficial appeal of the government's contention that the plain language of section 666(b) includes the patient assignments to BVMG. *See LaHue*, 998 F.Supp. at 1187. The scope of section 666(b) jurisdiction reaches any organization that "receives . . . benefits" from a federal program in an amount over $10,000. 18 U.S.C. § 666(b).

Medicare is indisputably a federal program and BVMG did receive reimbursements in any one year in excess of $10,000 for its physicians' services to Medicare recipients.

In support of this argument, the government offers an analogy to anti-discrimination statutes, contending that "section 666 'expressly equates "benefits" with "Federal assistance." ' " Br. of Aplt. at 15 (quoting *United States v. Rooney*, 986 F.2d 31, 34 (2d Cir.1993)). The government then directs us to cases holding that providers who accept Medicare funds receive "federal assistance" under an anti-discrimination statute. *Id.* at 16 (citing *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1042-48 (5th Cir.1984)). The government concludes by analogy that a health care provider who accepts Medicare funds thereby receives federal benefits and accordingly falls within the scope of section 666.

We are not persuaded by the analogy to anti-discrimination statutes, which are civil rather than criminal. We must exercise particular restraint in interpreting federal criminal statutes. *Dowling*, 473 U.S. at 214, 105 S.Ct. 3127. Moreover, there are inherent policy differences between these criminal and civil statutes.[4] Section 666 was designed to prevent diversions of federal funds enroute to their intended beneficiaries, whereas the anti-discrimination statutes were enacted to prevent the use of federal

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[4] We note in this regard that in *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039 (5th Cir.1984), the court expressly grounded its holding on the legislative history of the anti-discrimination statutes, judicial decisions construing them, and regulations adopted under them. *See id.* at 1042.

funds to support discrimination. *See United States v. Wyncoop*, 11 F.3d 119, 123 (9th Cir.1993) (Title IX anti-discrimination provision different in purpose and language from section 666).

Finally, like the district court, we believe that a closer look at the government's position reveals ambiguity in the plain meaning of section 666. Under the government's interpretation of section 666(b), any organization that is assigned $10,000 in a year in funds initially disbursed under a federal program source would fall within the statute. Thus, when funds have passed to the beneficiary and she assigns the funds further to any number of organizations which may assign them even further, the government's theory suggests that these monies are all considered benefits as long as they originated under a federal benefits program. Presumably under this interpretation, if the recipient physician endorsed Medicare checks to pay a supplier of medical goods, the supplier would be receiving benefits from a federal program. As the district court aptly noted, this construction creates almost a limitless statutory reach beyond a plain commonsense interpretation of the statute. *See LaHue*, 998 F.Supp. at 1187.[5] Even in the context of anti-discrimination statutes, the Supreme Court has distinguished

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[5] We note that § 666(c) refines § 666(b) by carving out certain transactions in the ordinary course of business: "This section does not apply to bona fide salary, wages, fees, or other compensation paid, or expenses paid or reimbursed, in the usual course of business." 18 U.S.C. § 666(c). *Cf. United States v. Copeland*, 143 F.3d 1439 (11th Cir.1998) (holding § 666(b) inapplicable to defense contractor without referencing § 666(c)). Neither the parties nor the district court addressed § 666(c), however. Since there are no circuit cases addressing § 666(c)'s application to § 666(b), we leave that analysis for another day. *See United States v. Grossi*, 143 F.3d 348, 350-51 (7th Cir.1998) (declining to decide whether certain payments have met § 666(c) requirements where the parties did not argue the issue below); *United States v. Mills*, 140 F.3d 630 (6th Cir.1998) (determining that § 666(c) applies to § 666(a)). We merely introduce § 666(c) as an additional legal wrinkle that contributes to the ambiguity of § 666(b).

between direct and indirect beneficiaries, holding that "federal coverage [does not follow] the aid past the recipient to those who merely benefit from the aid." *United States Dept. of Trans. v. Paralyzed Veterans of America*, 477 U.S. 597, 607, 106 S.Ct. 2705, 91 L.Ed.2d 494 (1986) (construing 29 U.S.C. § 794 prohibition against subjecting handicapped individuals "to discrimination under any program or activity receiving Federal financial assistance."). In so holding, the Court pointed out that if the statutes were construed to extend to all those who receive an indirect economic benefit from the federal assistance, "[t]he statutory 'limitation' on [the anti-discrimination statute's] coverage would virtually disappear, a result Congress surely did not intend."[6] *Id.* at 609, 106 S.Ct.

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[6] In New York Conference of *Blue Cross v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), the Supreme Court similarly refused to extend a statutory phrase to its full expansive meaning.

> The governing text of ERISA is clearly expansive. Section 514(a) marks for pre-emption "all state laws insofar as they . . . *relate* to any employee benefit plan" covered by ERISA, and one might be excused for wondering, at first blush, whether the words of limitation ("insofar as they . . . relate") do much limiting. *If "relate to" were taken to extend to the furthest stretch of its indeterminancy, then for all practical purposes pre-emption would never run its course, for*

2705. Similarly, in our judgment, the implausibility that Congress intended this limitless result in a criminal statute creates an ambiguity regarding the meaning of just who "receives . . . benefits . . . under a Federal Program," within the meaning of section 666(b).

Like other courts that have wrestled with an interpretation of section 666(b), we look to the legislative history and the underlying purpose of the statute for guidance. *See United States v. Copeland*, 143 F.3d 1439, 1441 (11th Cir.1998); *United States v. Rooney*, 37 F.3d 847, 850-51 (2d Cir.1994); *United States v. Wyncoop*, 11 F.3d 119, 121 (9th Cir.1993). The legislative history reveals that although Congress intended "federal programs" to be broadly construed, Congress also intended to limit the statute to be consistent with its underlying purpose to "protect the integrity of the vast sums of money distributed through federal programs from theft, fraud, and undue influence by bribery." S.Rep. No. 95-225, at 370 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3511. As further explained by our sister circuit, the purpose of section 666 is

> to prevent diversions of federal funds not only by agents of organizations that are direct beneficiaries of federal benefits funds, but by agents of organizations to whom such funds are

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> *"[r]eally, universally, relations stop nowhere,"* H. James, Roderick Hudson xli (New York ed., World's Classics 1980). But that, of course, would be to read Congress's words of limitation as mere sham. . . .

Id. at 655, 115 S.Ct. 1671 (emphasis added).

> 'disbursed' for further 'distribut[ion]' to or for the benefit of the individual beneficiaries.

United States v. Zyskind, 118 F.3d 113, 116 (2d Cir.1997).

When Congress enacted section 666, it cited three cases that represent the types of situations section 666 was intended to cover. See S.Rep. No. 95-225, at 370 nn. 2 & 3, *reprinted in* 1984 U.S.C.C.A.N. at 3182, 3511 nn. 2 & 3; *see also Salinas*, 552 U.S. at ___, 118 S.Ct. at 474 (discussing legislative history). In all three cases, the organization in question received federal program funds as the intended recipient, and each was charged with the responsibility for administering or spending the federal grant monies to benefit the intended beneficiaries. In *United States v. Del Toro*, 513 F.2d 656, 661 (2d Cir.1975), the Harlem-East Harlem Model Cities Program (Model Cities) received funds for revitalization projects in inner city areas. Model Cities had the responsibility to administer and disburse funds to benefit the communities. In *United States v. Hinton*, 683 F.2d 195, 196 (7th Cir.1982), United Neighborhoods, Inc. (UNI) entered into contracts with the city of Peoria, Illinois, to administer federal funds under a Community Development Block Grant from HUD. The intended beneficiary, again, was the community and UNI was charged with the administration and disbursement of federal funds to benefit that community. In *United States v. Mosley*, 659 F.2d 812, 813 (7th Cir.1981), the State of Illinois Bureau of Employment Security as part of the Comprehensive Employment and Training Program administered employment and training programs for the unemployed, the intended beneficiaries. The Bureau received the funds and had the responsibility to administer them to benefit the unemployed. None of the cases

represent a situation where the beneficiary had already received the benefits.

The purpose of section 666 to prevent the diversion of federal program funds on the distribution path to the intended beneficiaries is fulfilled once the funds have been received by the actual beneficiary. Cases interpreting section 666(b) support this conclusion. In *U.S. v. Wyncoop,* 11 F.3d 119, a private college participated in federal student loan programs. The issue was whether the college's receipt of tuition payments funded by the loans qualified as receipt of benefits under section 666. In the program, the government guaranteed the student's loan and a private bank then issued a check, often jointly to the student and the college. The student was the intended beneficiary of the loans. The college had no responsibility to administer or disburse the funds to the student. The court held that "the statute was not intended to cover thefts from institutions like Trend College that do not themselves receive and administer federal funds." *Id.* at 122.

In both *Wyncoop* and the instant case, the beneficiary had discretionary rights to the money. Although the court in *Wyncoop* did not emphasize the fact, we believe it was important to the outcome of the case that the checks were issued either to the students or jointly to the students and the school. The loans were thus made to the students and passed on to the college in the form of tuition payments. As such, the court's ultimate determination that the college did not receive "benefits" within the meaning of section 666(b) is consistent with our conclusion in this case. Here, the private insurance company administering

the Medicare benefits issued a check to the BVMG physician only after an assignment of the fees by the patient to the physician.

In *U.S. v. Zyskind,* 118 F.3d 113, the issue was whether an adult home that received federal funds as a contracted fiduciary thereby received a benefit within the meaning of section 666(b). The home, Hi-Li, served handicapped or mentally impaired adults. Most of the residents received federal benefits from either the Social Security Administration or the Department of Veterans Affairs. The statutory scheme envisioned that the federal funds could be paid to a caretaker or custodian in a fiduciary capacity for the benefit of the veteran. *Id.* at 115. Under that scheme, some benefit checks were made payable directly to the Hi-Li administrator as legal custodian of the veteran. The court held that since the funds reached Hi-Li before the veterans and Hi-Li was required to administer the funds on behalf of these intended beneficiaries, Hi-Li fell within section 666 jurisdiction. *Id.* at 117.

Zyskind is distinguishable from the instant case. There, Hi-Li received the money directly and was charged with a fiduciary responsibility to use the money for the benefit of the intended beneficiary, the resident. True to the purposes of section 666 to protect federal funds enroute to the beneficiary, the court upheld section 666 coverage over Hi-Li. By contrast, BVMG was merely accepting each patient's payment by voluntary assignment for services already rendered. BVMG had no power

or duty to administer or disburse the funds further to the benefit of its Medicare patients.[7]

We conclude that Congress intended the reference in section 666(b) to an organization receiving federal program benefits to mean one that receives benefits before final distribution to the intended beneficiary, here the patient. What happens to the funds once the patient receives them is beyond the scope of section 666. Thus, any assignment of such funds to a third party does not constitute a receipt of federal program benefits within the reach of section 666. We are not persuaded it was Congress's intent in enacting section 666(b) to follow the intended beneficiaries' further distribution of the federal benefits. As a result, we hold that BVMG falls outside the scope of section 666.

We **AFFIRM** the district court.

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[7] The government argues that "basing statutory coverage on whether federal payments are for past or future services . . . has been rejected as 'frivolous.' " Br. of Aplt. at 20 (citing *Baylor University*, 736 F.2d at 1048). What the government ignores is that *Baylor University* was a civil case and involved Medicare Part A. Medicare Part A is a different scheme where all payments to the hospitals are direct, without the voluntary choice of the patient. We need *not* decide whether the scope of section 666 would extend to such a case.